STATE OF MISSOURI
DEPARTMENT OF INSURANCE

MEDICAL PROFESSIONAL LIABILITY INSURANCE CLAIM REPORT

MAIL TO:
STATISTICS SECTION
P.O. BOX 690
JEFFERSON CITY, MO 65102-0690

1a NAME OF INSURER		1b CLAIM FILE IDENTIFICATION	1c NAIC GROUP & COMPANY CODE
2a DATE OF INJURY	2b DATE REPORTED TO INSURER	2c DATE REOPENED	2d ORIGINAL CLAIM ID NUMBER
3 LICENSE NUMBER	3a INSURED LAST NAME/HOSPITAL/OTHER:	FIRST NAME	SUFFIX (MD, DO, ETC)
3b AGE	3c CITY	3d STATE	3e ZIP

4 LICENSE NUMBER			
4a NAME OF INDIVIDUAL HEALTH PROFESSIONAL INVOLVED IN CLAIM (LAST NAME)	FIRST NAME	MIDDLE NAME	SUFFIX (MD, DO, ETC.)
4b STREET	4c CITY	4d STATE	4e ZIP / 4f TELEPHONE NUMBER
5a NAME OF PERSON ALLEGED TO HAVE CAUSED CLAIM, IF OTHER THAN THE INSURED (LAST NAME)	FIRST NAME	MIDDLE NAME	SUFFIX (MD, DO, ETC.)
5b STREET	5c CITY	5d STATE	5e ZIP / 5f TELEPHONE NUMBER

6a PROFESSION CODE OF INSURED	6b SPECIALTY CODE	6c TYPE OF PRACTICE CODE	7a PLACE WHERE INJURY OCCURRED CODE	7b CITY	7c STATE	7d ZIP

8a NAME OF INSTITUTION (IF INJURY OCCURRED IN INSTITUTION	8b LOCATION OF INSTITUTION CODE

9a INJURED PERSON'S NAME (LAST NAME)	FIRST NAME	MIDDLE NAME	9b AGE	9c SEX	9d DATE OF BIRTH	9j SOCIAL SECURITY NO.

9e STREET	9f CITY	9g STATE	9h ZIP	9i TELEPHONE NUMBER

10a PERSON INSTITUTING CLAIM IF INJURED PARTY IS DECEASED OR A MINOR (LAST NAME)	FIRST NAME	MIDDLE NAME	10f SOCIAL SECURITY NO.

10b STREET	10c CITY	10d ZIP	10e TELEPHONE NUMBER

11a TOTAL DEFENDANTS INVOLVED IN CLAIM	11b DERIVATIVE CLAIM CODE	12a AMOUNT OF RESERVE OR INDEMNITY IF OUTSTANDING	12b AMOUNT OF RESERVE FOR EXPENSE IF STILL OUTSTANDING

13a PLAINTIFF ATTORNEY'S NAME	13b CITY	13c STATE	13d ZIP

14. NATURE AND SUBSTANCE OF CLAIM

14a ACT OR OMISSION CODES (ENTER THREE DIGIT CODE IN APPROPRIATE CATEGORY)

Diagnosis Related ☐ Anesthesia Related ☐ Surgery Related ☐ Medication Related ☐ Intravenous & Blood Products Related ☐

Obstetrics Related ☐ Treatment Related ☐ Monitoring Related ☐ Biomedical Equipment/Product Medication Related ☐ Miscellaneous Related ☐

15. SEVERITY OF INJURY CODE

16. COMPANION CLAIM FILE IDENTIFICATION

1. 2. 3. 4.

17. DATE OF THIS PAYMENT OR CLOSURE	18. CLAIM DISPOSITION CODE	19. SETTLEMENT CODE

20 COURT CODE	20b NAME OF COURT	20c DOCKET NUMBER	20d DATE SUIT WAS FILED

21 Indemnity paid by you on behalf of this defendant	$	25. All other allocated loss adjustment expense paid by you	$
21a Economic damages	$	26. Injured person's incurred medical expense	$
21b Non-economic damages	$	27. Injured person's anticipated future medical expense	$
21c Punitive damages	$	28. Injured person's incurred wage loss	$
22. Other indemnity paid by or on behalf of this defendant	$	29. Injured person's anticipated wage loss	$
23. Indemnity paid by all parties (for all defendants)	$	30. Injured person's other expenses	$
24. Loss adjustment expense paid to defense counsel	$	31. Total amount allocated for future periodic pay (for all defendants)	$

CONTACT PERSON	TELEPHONE NUMBER	ADDRESS	PERSON RESPONSIBLE FOR REPORT

MEDICAL MALPRACTICE REPORT INSTRUCTIONS

Submit a report when a claim/demand for payment of damages is received in writing from claimant, a lien letter was received or a lawsuit has been filed. An incident is not to be reported until it becomes a claim. All claims closed without payment and claims with payment must be reported. Report all dollar amounts in whole dollars, all dates as MMYYYY. All open and closed reports are to be submitted to the Department of Insurance on a quarterly basis.

To report an open claim, Items 1 through 16 must be completed.

When a claim is closed, the total form must be completed.

1a. **Name of Insurer:** Enter name of company or self-insurer reporting this claim.

1b. **Claim File Identification:** Assign a distinguishing claim file identification number to each claim report. This number must be sufficient identification to enable tracing of a particular claim.

1c. **NAIC Group & Company Code:** Assigned NAIC codes to insurance companies, self-insurers contact Department of Insurance for assigned number.

2a. **Date of Injury:** Date of principal injury or alleged injury.

2b. **Date Reported:** Date when claim was first reported to insured.

2c. **Date Reopened:** Date claim was reopened.

2d. **Original Claim ID Number if claim is reopened:** If claim is reopened, original claim identification number used when claim was original filed with the Department.

3. **License Number of Health Care Professional:** Enter Missouri license number of insured, if unavailable, enter federal identification number, not applicable to clinics and corporations.

3a. **Insured's Name:** Enter name of insured defendant.

3b. **Age of Insured:** Enter age as of date of occurrence of insured name in 3a. If insured is an institution, group or partnership, enter 'N/A'.

3c. **City:** Enter city of insured named in 3a.

3d. **State:** Enter state of insured using two letter state abbreviation.

3e. **Zip:** Enter zip code of insured named in 3a.

4. **Name of Health Professional:** Enter license number, name and address of health professional involved in claim as shown in medical record. Attach list of names, if more than one.

5. **Name of Medical Practitioner Alleged to have Caused Claim, if other than Insured:** Enter name and address of person alleged to have caused claim if other than the insured named in 3a.

6a. **Profession Code of Insured:** Enter appropriate code for insured named in 3a.

(1) Physicians and Surgeons
(2) Hospitals
(3) Nurses
(4) Nursing Homes
(5) Dentists
(6) Pharmacies
(7) Optometrist
(8) Chiropractors
(9) Podiatrist/Chiropodist
(0) Clinics/Corporations/Other

6b. **Specialty Code:** Enter appropriate five-digit specialty code. Licensed insurers - use ISO Common Statistical Base Classification Code used for underwriting. Self-insurers - contact Department of Insurance for list of codes.

6c. **Type of Practice:** Enter one of the following codes if the insured named in 3a is a physician or other medical professional. Not applicable if hospital or health care facility is the insured.

(1) Institutional (including academic)
(2) Professional Corporation or Partnership (Group)
(3) Self-employed
(4) Employed Physician
(5) Employed Nurse
(6) All Other Employees
(7) Intern or Resident

7a. **Place Where Injury Occurred:** Enter the appropriate code for the place where the principal injury occurred:

(1) Hospital Inpatient Facility
(2) Emergency Room
(3) Hospital Outpatient Facility
(4) Nursing Home
(5) Physician's Office
(6) Patient's Home
(7) Other Outpatient Facility (including clinics)
(8) Other (describe place)

If the claim resulted from a diagnostic error, code place where error occurred, regardless of where it was discovered or treated.

7b. **City:** Enter city for place of injury coded in 7a.

7c. **State:** Enter two-letter state abbreviation for place of injury coded in 7a.

7d. **Zip:** Enter zip for place of injury coded in 7a.

8a. **Name of Institution:** Enter name of institution, if injury occurred in an institution (7a should be coded 1, 2, 3, 4, or 7). Otherwise, enter 'N/A'.

8b. **Location of Institutional Injury:** Enter appropriate code for location within institution where injury occurred:

(1) Patient's Room
(2) Labor and Delivery Room
(3) Operating Suite
(4) Recovery
(5) Critical Care Unit
(6) Special Procedure Room
(7) Nursery
(8) Radiology
(9) Physical Therapy Department

Applicable only when 7a is coded 1 or 4, otherwise enter 'N/A'.

9. **Injured Person's Identification:** Enter last name, first name of injured person, age on the date of injury, sex of injured person as 'M' (male) or 'F' (female), date of birth, street address, city, state, zip, telephone number and social security number of injured person.

10. **Person Instituting Claim if Injured Party is Deceased or a Minor:** Enter last name, first name, street, city, zip, telephone number and social security number of person instituting claim.

11a. **Total Defendants Involved in Claim:** Enter total number of defendants (persons and institutions other than John Does) involved in claim.

11b. **Derivative Claim:** Enter appropriate code if there was a derivative claim on behalf of someone other than the medically injured made by:

(1) Spouse
(2) Children
(3) Parent
(4) Personal Representative

12a. **Amount of Reserve for Indemnity Outstanding:** Enter amount.

12b. **Amount of Reserve for Expense Outstanding:** Enter amount.

13. **Plaintiff Attorney's Identification:** Enter name, city, state and zip of attorney.

14. **Nature and substance of claim:** Give a complete description of all actions and circumstances causing the claim. Include allegations made by claimant.

14a. **Act or Omission Codes:** Identify the relationship to claim: Diagnosis, Anesthesia, Surgery, Medication, Intravenous and Blood Products, Obstetrics, Treatment, Monitoring, Biomedical Equipment/Product, Miscellaneous. Enter the appropriate three-digit omission code. List of omission codes available from the Missouri Department of Insurance.

15. **Severity of Injury:** Enter severity of injury from scale provided below. Code principal injury if several injuries are involved.

	Severity of Injury Scale	Examples
Temporary	(1) Emotional Only	Fright, no physical damage
	(2) Insignificant	Lacerations, contusions, minor scars, rash. No delay.
Temporary	(3) Minor	Infections, misset fracture, fall in hospital. Recovery delayed.
Temporary	(4) Major	Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
Permanent	(5) Minor	Loss of fingers, loss or damage to organs. Includes nondisabling injuries
Permanent	(6) Significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung.
Permanent	(7) Major	Paraplegia, blindness, loss of two limbs, brain damage.
Permanent	(8) Grave	Quadriplegia, severe brain damage, life long care or fatal prognosis.
	(9) Death	

16. **Companion Claim File Identification:** Enter complete claim file identification numbers for all claims against other defendants involved in this same incident.

17. **Date of this Payment or Closure:** Enter date. When reporting a reopened case, enter new closure date.

18. **Claim Disposition Code:** For all claims, enter final method of claim disposition:
(1) Settled by parties before initiation of court proceedings.
(2) Settled by parties after initiation of court proceedings.
(3) Disposed of by court.

19. **Settlement Code:** Enter the appropriate settlement code.
(1) Before filing suit or demanding arbitration hearing
(2) Before trial or hearing
(3) During trial or hearing
(4) After trial or hearing, but before judgment or decision (award)
(5) After judgment or decision, but before appeal
(6) During appeal
(7) After appeal
(8) Claim or suit abandoned by plaintiff
(9) During review panel or nonbinding arbitration

20. **Court Code:** For all claims, enter the appropriate court code:
(0) No court proceedings were initiated
(1) Direct verdict for plaintiff
(2) Direct verdict for defendant
(3) Judgment notwithstanding verdict for plaintiff (judgment for defendant)
(4) Judgment notwithstanding verdict for defendant (judgment for plaintiff)
(5) Judgment for plaintiff
(6) Judgment for defendant
(7) Judgment for plaintiff after appeal
(8) Judgment for defendant after appeal
(9) All other (including dismissals and claims settled after initiation of court proceedings)

20b-d. **Name of Court, Docket Number and Date Suit was Filed:** Enter full name of court, docket number and date suit was filed.

21. **Indemnity Paid by you on Behalf of this Defendant:** Enter indemnity paid by you on behalf of this defendant. If more than one policy is involved, total the amounts paid by you under all policies.

21a. **Economic Damages:** Enter from item 21a, the amount of damages arising from pecuniary harm including, without limitation, medical damages and those damages arising from lost wages and lost earning capacity.

21b. **Non-Economic Damages:** Enter from item 21a, the amount of damages arising from non-pecuniary harm including, without limitation, pain, suffering, mental anguish, inconvenience, physical impairment, disfigurement, loss of capacity to enjoy life and loss of consortium but shall not include punitive damages.

21c. **Punitive Damages:** Enter from item 21a, the amount of punitive damages intended to punish or deter willful, wanton or malicious misconduct.

22. **Other Indemnity Paid by or on Behalf of Defendant:** Enter all indemnity paid by other parties on behalf of this defendant.

23. **Indemnity Paid by all Parties (For all Defendants):** Enter all indemnity paid by all parties on behalf of all defendants involved in this claim. This total should include any amount entered in line 31, 'total amount allocated for future periodic payments'.

24. **Loss Adjustment Expense Paid to Defense Counsel:** Enter loss adjustment expense paid by you to defense counsel for this defendant.

25. **All Other Allocated Adjustment Expense Paid by You:** Enter all allocated loss adjustment expense paid by you for this defendant. Include filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.

For questions 25 through 30, actual amounts should be reported, if unknown, report estimated amounts. If estimated amounts are reported, please indicate accordingly.

26. **Injured Person's Incurred Medical Expense:** Enter amount of incurred medical expense from date of injury to date of closure.

27. **Injured Person's Anticipated Future Medical Expense:** Enter total future medical expense if it appears the claimant will incur expenses in the future.

28. **Injured Person's Incurred Wage Loss:** Enter amount of wage loss from date of injury to date of closure.

29. **Injured Person's Anticipated Future Wage Loss:** Enter total future wage loss if it appears the claimant will incur wage loss in the future.

30. **Injured Person's Other Expenses:** Enter amount of incurred plus future expense for substitute services and all other expense. Include funeral expenses here.

31. **Total Amount Allocated for Future Periodic Payments (For All Defendants):** If a reserve annuity, trust fund or similar mechanism was established to provide future periodic payments, enter the total amount thereof. This amount should be included in line 22, 'indemnity paid by all'. The amount allocated to the insured defendant reported in this claim must also be entered in line 21 or 22 whichever is applicable.